

# BEDSIDE MEDICINE FOR BEDSIDE DOCTORS

An Open Forum for brief discussions of the workaday problems of the bedside doctor. Suggestions of subjects for discussions invited.

## APPENDICITIS

GEORGE K. RHODES, M.D. (490 Post Street, San Francisco).—In discussing the subject of factors influencing diagnosis and prognosis in acute appendicitis, we must ask ourselves some very pertinent questions:

1. Why is the mortality from appendicitis operations higher in the United States than in any other country in the world?<sup>1</sup> There must be some explanation for these mortality rates per 100,000: Italy, 3.7; England, 7.1; Germany, 9.0; United States, 15.2.

Davis,<sup>2</sup> in a survey of United States vital reports, tells us of a gradual increase from 9.7 deaths per 100,000 population in 1900 to 15 in 1927, an increase of 34.7 per cent.

Is the morbidity greater, or do we have more violent pathology? Is poorer surgery done?

2. Is the treatment of appendicitis properly standardized, as are other procedures designed to combat specific disease? Have we not all seen unfortunate fatalities from appendicitis which possibly were attributable to certain errors of judgment either before, during, or after operation?

Such illuminating statistical studies of appendicitis as those conducted by the Philadelphia Department of Health should stimulate other systematic investigations. Statistical studies, to be of any value, must be based upon comparable conditions of disease. In such a series of cases, would the results of the well-trained surgeon be essentially those of the surgeon whose experience is more limited? Is our high mortality the result of surgical technique or serious pathology?

The ultimate prognosis of the disease, acute appendicitis, must depend upon early diagnosis, adequate surgery, and intelligent postoperative care.

*Diagnosis.*—To become "appendicitis minded" we must look upon every acute abdominal complaint as appendicitis until such a diagnosis is definitely eliminated by careful systematic investigation. The underlying pathology of acute appendicitis is that of an acute inflammation of the appendix, which is secondary to septic emboli or an exacerbation due to more chronic lesions as a kink or stricture with or without fecalith, etc. Here we find the usual gradual sequence of a pathologic state resulting from an obstructed blind viscus with its circulation damaged. Accordingly we should not expect the complete clinical picture to develop instantaneously, as seen in the instance of acute perforated peptic ulcer.

There usually is a lapse of six to eight hours before sufficient inflammation has developed to show general and local signs of inflammation, *i. e.*, fever, local tenderness, muscle spasm, rebound tenderness, leukocytosis, etc. It is during this early six to eight-hour period that both the patient and his doctor are most often deceived as to the serious nature of the incipient disease. Often the only evidences of appendicitis at this period are those subjective symptoms of abdominal pain, usually referred to the epigastrium, followed by nausea and vomiting.

If, however, our patient is seen after eight hours, the correct diagnosis is usually very evident. By this time the general or epigastric distress has shifted to a "soreness" in the right lower quadrant, and there are exacerbations of colic pains in this region. The temperature and leukocytes are now usually elevated. The classical signs of early peritonitis begin to supervene.

In the differential diagnosis the following disorders must be definitely considered: gynecologic, renal, biliary, gastro-intestinal, etc.

*Physical Examination.*—The usual physical findings upon abdominal examination also vary markedly with the degree of peritonitis present and the amount of parietal peritoneum involved in the process. The patient with an extensive or rapidly spreading peritonitis may show physical findings approximating in degree those found in an acute perforated peptic ulcer (*i. e.*, scaphoid and rigid abdomen, cessation of abdominal respiratory movements, "quiet" abdomen to auscultation, rebound tenderness, etc.). On the other hand, we may have an appendix developing as much pathologic changes and latent possibilities, which may give absolutely no abnormal physical signs, such as tenderness, muscle spasm, etc. At operation this type of appendix is usually found to be retrocecal or in the true pelvis or cul-de-sac. The latter type can be felt rectally, the former usually shows tenderness in the right flank.

*Temperature.*—We should never wait for an elevation of the temperature as a determinant factor for or against operation. Too often the temperature may remain normal in association with severe disease of the appendix. Rectal temperatures should be taken routinely.

*Laboratory Findings.*—While it is true that there usually is a moderate leukocytosis and a relative increase in polymorphonuclear elements, we must *not* rely too strongly on such laboratory data as an indicator for or against surgery. We like to see the blood count dovetail into the classical clinical history and physical findings, but it never should supersede these all-important items as a diagnostic agent. There are many factors

<sup>1</sup> Hoffman, F. L.: Appendicitis Record for 1930, *The Spectator* (Aug. 27), 1931.

<sup>2</sup> Davis, B. B.: Why Is Mortality of Appendicitis Increasing? *Neb. State Med. J.* (Feb.), 1931.

which may influence and cause a variation in blood counts. (The blood count showing a leukopenia may help the decision of diagnosis in favor of such less acute clinical manifestations as intestinal influenza, tuberculosis, typhoid, etc.).

*The Time to Operate.*—The general rule to operate just as soon as the diagnosis is made would meet with the approval of most surgeons in most instances. No one of experience can honestly estimate accurately the extent of the disease present in the appendix before operation. So much depends upon the initiating factors, such as kinks, fecaliths, etc., which differ in each instance. We have all seen a patient develop an acute gangrenous, perforated appendix within six hours after the onset of clinical symptoms, while the very next patient might have required seventy-two hours to develop the same degree of pathologic change. Such observed facts should show the fallacy of placing any time element as a determinant factor for urging an individual operation.

*General Contraindications for Immediate Surgery.*—Every experienced surgeon reaches his conclusions not to operate immediately upon a particular group of patients because his surgical judgment tells him that patients falling into this class do poorly with radical surgery. Furthermore, he knows that many members of this group respond well to conservative treatment and delayed surgery. Into this group my own experience tends to place the patients with the following symptoms and signs:

1. Poor general physical condition, either from other coincidental disease, such as cardiac and lung lesions, or those debilitated from long sepsis or toxic state.

2. A peritonitis that from physical signs and general body reaction seems unusually acute and fulminating. The pulse is rapid and the volume is impaired. Often there is other evidence of threatened circulatory failure. This condition is seen frequently in children.

This group of patients undoubtedly will do much better if operation is deferred until a conservative type of therapy can build up the general and local resistance of the patient. The so-called Ochsner type of conservative therapy has its ideal application in the patients of this group. In many of these patients so treated, nature will ultimately reduce the surgery indicated into simple incision and drainage of a localized abscess. Usually the abscess points into the cul-de-sac and should be opened rectally when possible.

*Anesthetic.*—Undoubtedly an ill-chosen or poorly administered anesthetic may be a factor of considerable importance in our ultimate results. The surgeon will use that anesthetic which in his hands gives the best results. My own choice in all acute abdominal surgery is a spinal anesthetic, unless special contraindications to its use are present. The complete relaxation obtained certainly facilitates the exposure with the minimum of trauma, traction, and contamination.

*Operative Procedure—Incision.*—There are two general incisions, each with its good points and faults.

*McBurney Type Incision.*—When one is accustomed to this incision it would seem the most logical procedure in most instances.

Arguments in favor of muscle-splitting, McBurney Type, incision in acute appendicitis:

1. Direct approach to the area with the minimum trauma and contamination of the general peritoneal cavity.

2. Abdominal drainage through a McBurney incision affords the shortest route to the skin.

3. Statistics show that there are far fewer post-operative ventral herniae following drained suppurative muscle-splitting wounds than in other types of infected laparotomy incisions.

4. Secondary operations during convalescence (as for intestinal obstruction, etc.), are facilitated by the suppurating wound being in the right lower quadrant and away from the newly contemplated laparotomy wound.

5. Patient becomes ambulatory much sooner.

6. A general exploratory laparotomy incision is seldom needed for such limited and localized pathology.

Arguments against the McBurney type, muscle-splitting incision:

Chiefly those associated with inadequate exposure.

*Right Rectus Type of Incision.*—Arguments in its favor:

1. Free and adequate exposure.

Arguments against:

1. Danger of disturbing a localized abscess in the right lower quadrant so that the entire abdominal cavity is thus contaminated.

2. Possible sequelae from establishing suppurative abdominal drainage through a rectus incision (partial evisceration, etc.).

Possibility of further spreading a local peritonitis to one more general.

Possibility of producing extensive intestinal adhesions about the drains which traverse the abdominal cavity.

*Treatment of the Diseased Appendix.*—If the appendix be not ruptured, it should be removed cautiously and the stump treated as in the more chronic type. Careful toilet of the peritoneum and peritonealization of all raw surfaces of the meso-appendix and of the stump would seem the safest assurance against future trouble. Great care must be taken to prevent the needle entering the lumen of the bowel with resultant contamination. Those who advocate not covering the appendiceal stump in these cases must not entirely discount the testimony of many observers who report instances of intestinal obstruction developing later.

If the appendix is ruptured and is easily removed, such should be the procedure.

If the appendix is not easily identified or is so intimately involved in a chronic abscess wall, it is often advisable to drain the abscess only, and remove the appendix at some more favorable time.

If the appendiceal abscess is definitely localized in the pelvis, it is undoubtedly safer to drain it

through the rectum than to make an abdominal approach and further contaminate the general abdominal cavity.

*Drainage.*—Extensive clinical and laboratory studies on acute peritonitis are proving to us that the dictum "when in doubt, don't drain" will save more souls than that older thought so religiously practiced, "when in doubt, drain." Laboratory work proves conclusively that drains do not really drain the abdominal cavity but act as foreign bodies which are completely walled off in a few hours by becoming encased in a tube of fibrin surrounded by abdominal viscera. Such foreign bodies also aggravate peritonitis in experimental studies.

*Type of Drains.*—The hard rubber tube with its frequent sequelae of pressure sloughs, fistulae, and hemorrhage, etc., has been almost entirely discarded in favor of soft rubber tissue drains of the cigarette type. These should be shortened gradually each day to allow the abscess cavity to collapse as the drainage tract is developed.

*Preoperative and Postoperative Treatment.*—If the patient falls into that group previously described as poor operative risks, he should be treated conservatively, after the manner popularized by Ochsner.

If the patient is considered a satisfactory risk, no special preliminary preparation is necessary other than routine sedatives and fluids by clysis or intravenous routes. The use of large enemas, either preoperatively or postoperatively, are mentioned only to be condemned.

*Treatment of Peritonitis.*—If operation discloses the evidence of early peritonitis, then every measure to combat and anticipate a fatal paralytic ileum, etc., should be instituted at once. These measures should include:

1. Massive hot abdominal stupes.
2. Intravenous administration of glucose solution, 10 per cent (2,000 cubic centimeters daily).
3. Hypodermoclysis, 2,000 to 3,000 cubic centimeters normal saline solution daily.
4. Continuous gastric lavage with nasal tube.
5. Low colonic flushes, fluid volume not to exceed 500 cubic centimeters.
6. Limited fluid intake by mouth.

If clinical evidence of paralytic ileus still progresses in spite of these therapeutic measures, pituitrin in one-half to one cubic centimeter doses may be given every four hours, followed by low colonic flushes, 500 cubic centimeters. A carefully placed enterostomy tube into the jejunum through a small left rectus incision often will avoid an otherwise inevitably fatal issue. The enterostomy catheter is more safely introduced if the loop of jejunum be first isolated between intestinal clamps, and collapsed.

*Postoperative Mechanical Obstruction.*—Postoperative mechanical obstruction occasionally develops when loops of terminal ileum become matted to the wall of the abscess cavity or intra-abdominal drains. Inasmuch as this type of ob-

struction is often only in part mechanical and part paralytic, a jejunostomy tube will correct the pathologic picture.

*Conclusions.*—If we are to stem the lamentable tide of ever-increasing mortality statistics we must begin to take this disease out of the discard and become "appendicitis minded" again. The issue probably is not so much one of error in diagnosis as one of careless and improper treatment of a very common disorder.

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E. ERIC LARSON, M. D. (1930 Wilshire Boulevard, Los Angeles).—Appendicitis is one of our most common diseases. In nearly all instances it is readily detected by the physician. The layman is also becoming quite proficient in sensing this condition when there is abdominal distress. The treatment is fairly well defined and is universally the same. Some notes regarding its treatment are here submitted.

Statistics, as shown by a recent bulletin of the American College of Surgeons, reveal that twenty thousand persons die annually in the United States from appendicitis and its complications. The death rate in the United States is 124 per cent greater than in Europe. Each patient having appendicitis has one chance in thirty-eight of not recovering. The mortality has increased 31.5 per cent in the last twenty years in sixty of our largest cities. In proportion to the population of Los Angeles, according to the Department of Vital Statistics, the number of deaths from appendicitis over a ten-year period is as follows:

Year	Deaths	Population
1922 .....	88	736,963
1927 .....	131	1,079,789
1932 .....	177	1,283,859

Obviously there must be a reason for this progressive mortality. Except for the change in virility of bacteria, the pathology and bacteriology of the condition remain unchanged. The essential principles involved in dealing with the disease, both medically and surgically, have been practically the same during the past two decades. Our physicians and surgeons have opportunity to be much better trained in diagnosis and more skillful in surgical principles and technique. Why, then, are we compelled to admit this increasing mortality? The explanation may be, first, the lack of publicity and the apathy of the layman to this serious condition; second, cultist influence; third, injudicious practices by many of the medical profession and their failure to apply well-grounded knowledge.

There should be a frank discussion with the public regarding the mortality of appendicitis, when treated and when untreated. This should include the record of the individual surgeon and the institutional mortality in appendicitis. Recently a nonmedical columnist has suggested that all surgeons, as well as all hospitals, should publish mortality statistics in the same manner as banks issue their financial statements. News writers and editors should, in reporting deaths from appendicitis, not state that the patient died

from an operation for appendicitis, which gives the layman a false impression. Rather, the facts should be stated, that the patient died of appendicitis which an operation failed to cure because of delay resulting in peritonitis or whatever complication might have existed in the particular instance. Thus the public can be properly informed as to the true nature of the disease. The press might inform its readers that an abdominal distress suffered for a period of several hours should have definite management, that is, the forbidding of laxatives, restriction of intake by mouth, application of cold to the abdomen, and a call by the family physician for diagnosis. The family should be informed to insist that the doctor make necessary tests and ask for consultation, if necessary, to make the diagnosis as certain as possible.

The public should be told of the necessity of early diagnosis, with prompt and scientific management. The interval or healed appendix, the appendix removed secondarily during other abdominal operations, and the so-called chronically infected appendix, including tuberculous or mucocele type of pathology, are well handled by almost any operator, with a minimum mortality.

A case of acute appendicitis, however, is an altogether different problem, and is, of course, never stationary. It is progressing, either favorably or unfavorably, depending on whether the bacteria or the antibodies are ascendant. The condition may be mild and simple, or complicated and dangerous. A careful check of the history will reveal the duration of the attack, whether there have been repeated attacks, or whether there are present other signs pointing to early and serious complications. Immediate removal, if permissible, incurs little danger. The operation should not be delayed for the convenience of the surgeon when so much is at stake for the patient. If, however, the process has been allowed to be neglected, or if the patient is seen at a late stage when there are signs of generalized spread of infection, either into the abdominal cavity or the vascular radicals, the mortality risk is increased. An inexperienced, unqualified operator may cure many of the mild cases and thus build up a good reputation, whereas in the serious and neglected type even the master surgeon may fail to save his patient. In the latter instance we may fitly apply the oft-repeated dictum of John B. Deaver: "It may be too late for an early operation and too early for a late operation." The correct application of this dictum comes only when the surgeon is well trained, has had much experience and can apply good surgical judgment. It is through correct handling of these patients that we can lower the mortality in appendicitis.

Besides early diagnosis and expert surgical technique, the preoperative care of the advanced and neglected cases should have much consideration. The surgeon should visualize the existing intra-abdominal pathology, ever mindful of that "treacherous calm" often seen immediately following the rupture of the distended appendix or abscess.

He must determine to the best of his ability the general condition of the patient incident to the amount of intestinal stasis, the degree of dehydration caused by vomiting, and other physiologic factors. Clinical interpretation of accompanying disease elsewhere in the body, such as obesity, cardiovascular or kidney disease, is important. The surgeon may, in some instances, show better judgment in allowing an abscess to form, to be drained at a later date, than in subjecting his patient to immediate operation. These problems demand wisdom and experience.

Anesthesia is becoming much less of a problem. Ether is, and has always been, our safest inhalation anesthetic when properly administered. Nitrous oxid and oxygen or ethylene may, in the hands of expert anesthetists, be used with safety, but the loss of relaxation in a difficult operation may make the procedure hazardous. Spinal anesthesia properly employed gives perfect relaxation, enables the surgeon to perform his operation quickly, and minimizes the complications incident to surgery. There is usually very little shock to the patient, and the immediate postoperative recovery is less distressing. It appears that spinal anesthesia is being increasingly used.

Countless articles have been written, dealing with the various types of incisions, methods of caring for the stump, and drainage. Each method has its supporters and dissenters. The solution, however, will not be obtained until every surgeon and institution is able to classify all patients as to pathology, their general condition, bacteriology of the disease, and individual resistance to infection. In doing this we will use many thousands of classified instances in making statistics, thereby obtaining definite and valuable information and rewriting the story of appendicitis.

All qualified surgeons know that the incision must be placed directly over an abscess in order not to soil the abdominal cavity. For this reason the incision may, if necessary, be placed in almost any aspect of the lower abdomen. Whether or not the appendix is removed when the abscess is drained must also be left to the judgment of the surgeon. It is simple to remove the appendix at a later operation, with little attendant danger. The drainage problem must also be cautiously considered at the time of operation. The drains, if used, should be so placed that the coils of intestines do not encroach upon the drainage channel and later lead to adhesions and obstructions. The position of the patient may facilitate drainage. Since soft rubber drainage material has been universally used, we rarely see a fecal fistula.

The care of the stump may vary in the hands of each surgeon. Simply ligating the stump is apparently as justifiable a method of treatment as inversion or burying, if a good ligature is applied and careful toilet is maintained, and if the defect is placed in a position where a coil of intestine cannot become adherent.

Postoperatively the patient requires watchful care and expert management. He may need an

abundance of fluids, transfusions, serums, or more adequate drainage. There must be intelligent evaluation of the earliest signs of distant complications, such as pneumonia, liver or subphrenic abscess, kidney or cardiac damage. The too often forgotten enterostomy may become necessary for the relief of a severe and otherwise fatal ileus.

Postoperative ventral hernia following drainage often causes concern and may result in numerous inadequate operations for its cure. The use of autogenous fascia lata transplants has been effectively employed by many surgeons. These strips, taken from the thigh and placed in basket-weave formation, incorporate themselves into the existing fascia and give a solid and adequate abdominal wall.

A word should probably be said regarding the use of serums in postoperative management in very severe instances of generalized peritonitis. It is generally known that few humans harbor anaërobic bacteria. At the time that free pus is encountered in the abdominal cavity, cultures should be made for anaërobic as well as aërobic types of bacteria. Intravenous and subcutaneous injections of trivalent anaërobic serum have been used with startling results in many instances. Intra-abdominal vaccines, as well as the proper use of bacteriophage, will no doubt in time be available as a means of assisting in the treatment of the present fatal type of peritonitis.

*Summary.*—1. There is an appalling increase in the death rate from appendicitis, and the story must be rewritten.

2. The public must become educated to the seriousness of this common disease. Early diagnosis with prompt and efficient management will lower our mortality.

3. Besides the employment of careful surgical technique, the surgeon must evaluate the patient's condition, visualize the existing pathology, and use judgment as to where the incision is to be placed and how extensive an operation is to be done. The type of anesthetic plays an important part in the welfare of the patient.

4. The preoperative and postoperative care of the delayed or neglected patient requires study and diligence in maintaining the patient in as good a condition as is possible.

5. The use of serums, vaccines, and bacteriophage must not be underestimated.

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WILLARD T. CONLEY, M. D. (6331 Hollywood Boulevard, Los Angeles).—The profession for some time has been turning from some of its former views on the subject of appendicitis. The influences have come from the extensive work done in other fields in abdominal disease, and from other factors.

The realization is growing that appendicitis is not always a local entity, but is often the seat of the first reaction to a systemic invasion by bacteria. The general character of the disease which

is occasionally manifested by appendicitis often accounts for the continuance of the complaints after appendectomy. In a reverse order, symptoms may take on a systemic nature from an inflammatory process chiefly active in the appendix. This latter condition leads to a symptomatology that may not include all of the signs which make up what is still held to be the classical syndrome.

The observations made of new and old infections of the appendices in the new-born strengthen a suspicion of the general character of the disease, and result in the belief that histories of former attacks can be erroneously negative in patients who have recovered from their primary injury before birth. These often obscure the diagnosis until the patient drifts into serious or even fatal complications.

The lowering of the present high death rate rests, in a measure, on a careful consideration of the presence of appendicitis in all patients in whom gastric and nutritional disturbances are among the principal complaints.

The recognition of the general, as well as focal, symptoms of appendicitis will come through the application of the accepted principle of varied reactions to infections of the gall-bladder, stomach, and teeth. The local and general reactions aside, the symptoms are further modified by the position of the appendix, whether high or low in the abdomen, its relation to the peritoneum and mesentery, and the age of the patient.

For convenience, inflammations of the appendix can be divided into acute and chronic. In the acute forms the symptoms are more often local than general, such as: sudden general abdominal pain, later localizing over the lower right quadrant and accompanied by tenderness, rigidity and constipation; while the general signs are usually no more than nausea, vomiting, slight elevation of temperature and pulse rate, and leukocytosis. In the chronic forms the patient complains less of abdominal discomfort and more of what we deem the symptoms of general toxemia, malaise, unremitting muscle aches of arms and legs, occasional flashes of nausea, and gastric upsets. These are even more characteristic in their unresponsiveness to tonics, and are actually intensified by exercise. As the time approaches when the inflammatory process will pass beyond the tissues of the appendix, these general symptoms increase, especially those of digestion. The nausea becomes more pronounced, indigestion increases until nearly all foods are prohibited, fatigue and aching become almost unendurable. Constipation, of which the suffering individual has complained from the beginning, now requires, on his part, drastic purgatives—a resort that usually terminates the general complaints in one of an abdominal crisis, due to rupture of the appendix.

The appendix has been found in nearly all locations of the abdomen, but those considered most usual are: appendix hanging over the brim of the pelvis; appendix upward and medially pointing toward the spleen; and appendix upward behind the cecum.

Keith states that the paccian corpuscles, which are abundant in the mesentery and peritoneum, when irritated cause a reflex immobility of the abdominal wall. Tyrrell-Gray observed that such irritation excites sympathetic inhibitory impulses, producing ileus and vomiting. The mechanism set into action by irritation of the nerves of the mesentery hyperactivates includes:

(a) The efferent sympathetic, resulting in inhibition of the terminal ileum and cecum.

(b) The afferent sympathetic, the efferent response evoking: (1) Proportionate immobility of the whole intestinal tract, and (2) proportionate closure of the pylorus against the passage of food.

(c) The afferent vagus, the resultant contraction of the proximal stomach against a closed pylorus emptying that viscus of food.

Deaver states that local pain increases with the proximity of the appendix to the parietal peritoneum, and that pain may be referred to the right lumbar region, right thigh or right testicle through impulses reaching the superior mesenteric plexus through a branch supplying the appendix, and transmitted to the part of the spinal cord which gives off the lower dorsal and lumbar nerves.

When the appendix is in the retrocecal position, pain may be complained of in the right loin, liver, or right kidney regions. Tenderness is often both superficial and deep, though it may be diminished when the appendix is in the pelvis. Nausea is more constant as a symptom than vomiting. Some observers say that both may be absent. However, the common experience is that nausea in some degree is usually present during acute attacks.

In the chronic forms of appendicitis the inflammatory reaction may not include any of the surrounding area, and consequently local tenderness, rigidity, and even constipation, may not be found. Pain may be absent where there still remains free drainage for appendiceal contents, but disturbed digestion is present, as it arises from irritation of the rich nerve supply in the wall of the appendix. McDonell recently reported a rigidity of the upper right rectus, when accompanied by persistent fatigue and indigestion, as a sign of chronic appendicitis. Buchman observed in thirty-five hundred cases dilatation of the right pupil in 88 per cent, and of the left pupil in 6 per cent.

The reaction of tissues is altered by age. Old people may have none of the classical signs during an acute attack. Lewin reported twelve cases with left-sided pain, due to distention and upward displacement of the iliac coils, with incessant vomiting and total absence of signs in the lower right quadrant. In children the long mesentery permits the cecum to fall low in the pelvis. Pain on urination and defecation should be regarded seriously. Trotter says that colicky pains and delicate abdomen in children often result from appendicitis.

A differential leukocyte with Schillings' classification should be done routinely with every blood examination.

*A Bill Providing for a Council on Medical Ethics.*—For many years the physicians of France have been demanding the creation of an official council on medical ethics, patterned after that which exists for the lawyers and possessing the same privilege of judging alleged violations of professional honor, independently of the delicts that come under the jurisdiction of the ordinary courts. The Confédération des syndicats médicaux had assumed in part this rôle, but its decisions had no legal weight. But physicians are not all favorable to the idea; there are many who fear that such a tribunal may not always be impartial and that sometimes it may render decisions inspired by professional jealousy. The Academy of Medicine, when consulted on the subject a few years ago, gave an unfavorable opinion and proposed in preference a return to the ancient oath of Hippocrates, in connection with the conferring of the doctor's degree, and the creation of a course of instruction in professional deontology at the faculties of medicine. The question slumbered on until suddenly, December 8, 1932, at a morning session of the chamber of deputies, a bill providing for the creation of a council on medical ethics, presented by Deputy Xavier Vallat, was voted on and passed without examination or discussion, along with numerous other bills of secondary importance, being simply read to the assembly and voted on at once by show of hands, while the attention of parliament was centered on the discussion of the grave question of the debts owed to the United States. This decision, which is so important for the medical profession, resulted, therefore, from a surprise vote. However, the bill will not become a law until it has been approved by the senate, which, no doubt, will examine it more closely. Its essential stipulations, which as yet are not definitive, provide for the compulsory enrollment of every practicing physician in a chapter to be created in each department. Each chapter would elect a council composed of from six to twenty-four members, depending on the number of voters, and this council would select a president and a committee on discipline. Every professional misdemeanor would be judged by this council and the following penalties are provided for: (1) warning, (2) reprimand, (3) suspension of practice for a period not to exceed one year, and (4) removal of the offender's name from the roster of the council and definitive revocation of his license to practice medicine. There is established also a tribunal of appeal, which consists of two magistrates, one of whom is the president of the council. The decisions of the council are transmitted officially to the prefect of the department in question, whose duty it is to enforce the penalty of suspension or of removal from the register of physicians.—*Paris News Letter. (Journal of the American Medical Association.)*

*Complications of Common Cold.*—Yates believes that the common cold is devoid of complications except in the following circumstances: (1) When the discharges are confined within a sinus or within the middle ear by reason of the swelling of the mucous membrane, which interferes with drainage. (2) When there is a secondary infection from contact with a person whose nose contains micro-organisms that are resistant to the natural destructive powers of the nasal mucus and thus live and multiply within it. (3) When the mucus in the nose is diluted either by nasal douching or by bathing. (4) When the common cold affects a person who is in ill health. The complications of the common cold are found: (1) Within the nasal sinuses; diagnosed by the presence of pain and relieved in the early stages by cocainization of the nose and thus effecting drainage, and in the later stages by washing out the sinuses with liquid petrolatum. (2) Within the ear; acute otitis media is treated by efficient myringotomy (the sooner myringotomy is performed, the quicker the recovery). (3) Within the larynx and bronchi; laryngeal and bronchial complications are treated by sprays of liquid petrolatum, which aid the cilia in conveying the excess of mucus through the trachea and the larynx.—*Practitioner (London).*